STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155076	A. BUILDING **01** B. WING _____	R **11/07/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRICKYARD HEALTHCARE - BROOKVIEW CARE CENTER	**7145 E 21ST STREET** **INDIANAPOLIS, IN 46219**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS	{K 000}		

A Post Survey Revisit (PSR) to the PSR survey conducted on 10/07/22 to the Life Safety Code Recertification and State Licensure Survey conducted on 08/10/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).

Survey Date: 11/07/22

Facility Number: 000031
Provider Number: 155076
AIM Number: 100266150

At this PSR survey, Brickyard Healthcare-Brookview Care Center was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.

This facility, with the east and west wing consisting of one story and the subacute wing consisting of two stories and a basement, was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. All resident sleeping rooms were surveyed. The facility has a capacity of 136 and had a census of 74 at the time of this visit.

All areas where residents have customary access were sprinklered. The facility has one detached shed providing facility storage services which was

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	155076	A. BUILDING **01** B. WING _____	R **11/07/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRICKYARD HEALTHCARE - BROOKVIEW CARE CENTER	**7145 E 21ST STREET** **INDIANAPOLIS, IN 46219**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	Continued From page 1 not sprinklered. Quality Review completed on 11/07/22	{K 000}		